Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

See Article page 597 in the August 2020 issue.

Commentary: Collaboration is key to saving as many lives as possible

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CENTRAL MESSAGE

Sharing our successes, failures, and lessons learned with the thoracic surgical community is imperative to saving as many lives as possible during this pandemic.

THOR

In the August 2020 issue of the *Journal*, Chen and colleagues[1] share insights from the Chinese experience with Coronavirus Disease 2019 (COVID-19) for the benefit of improving thoracic surgical outcomes worldwide during this unprecedented time. This article is certainly timely, and at this moment, the information shared is likely of greater relevance to the majority of surgeons in our field than any other previous publication. This pandemic affects us all—all of our practices, all of our patients, all of our colleagues and communities. Based on Peng and colleagues'[2] cohort study of perioperative COVID-19 outcomes, as well as additional experience from the Chinese thoracic surgical workforce, this article[1] shares wisdom in attempts to lessen the global wreckage from the coronavirus.

Among Chen and colleagues'[1] suggestions, the first is aimed to minimize the spread of the virus from asymptomatic carriers, specifically with the use of universal precautions. However, the recommendation for treating all patients who come to the hospital for surgery with universal precautions is accompanied with the caveat that there is a presumption of adequate supplies. This, of course, is a challenging assumption, because it will vary on the basis of location, population density, financial resources, and phase of the surge, among many additional variables. In order to heed the advice provided here with regard to use of universal precautions, more work is currently needed to explore the challenges and potential solutions for addressing critical shortages of personal protective equipment (PPE).[3]

Chen and colleagues[1] go on to provide specific recommendations for common thoracic diseases, which are overall quite helpful. While these recommendations are geared toward the general thoracic surgeon, certainly, this is a time when similar guidance is being proposed to steer adult and congenital cardiac surgeons.[4,5] In terms of disease processes, Chen and colleagues[1] recommend cessation of operating for ground-glass lesions; first, because ground-glass predominant malignancies typically exhibit an indolent and favorable course, and second, because of challenges in discerning COVID-19–related imaging findings from those of pure ground-glass adenocarcinomas. With regard to N2-IIIA non–small cell lung cancer, Chen and colleagues[1] recommend consideration of induction therapy to delay surgery or deferral to definitive chemoradiation followed by immunotherapy, depending on additional patient factors. Moreover, for assessing the stage of non–small cell lung cancer patients, we are urged to rely on positron emission tomography, despite its inherent limitations, to reduce additional procedures of endobronchial ultrasound and mediastinoscopy, especially considering risk of aerosol generation with the former. For esophageal cancer, the suggestion is made to consider, for select patients, bimodal rather than trimodal therapy, with the caveat that salvage resection could be offered as needed after the pandemic. Finally, for patients with COVID-19 who require urgent or emergency surgical procedures, Chen and colleagues urge us not to abandon our patients in the greatest need, but also not to forget the importance of protecting ourselves and our teams with adequate PPE. These are all excellent recommendations and, for the large part, correspond with those recommendations made by the Thoracic Surgery

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Outcomes Research Network (ThORN) regarding triage of operations for thoracic malignancies during this pandemic.[6]

However, one of the strengths of the ThORN consensus statement is that all recommendations are based on the hospital's phase within the surge in terms of prevalence of patients with COVID-19 within the institution, availability of hospital resources, and rate of change.[6] Although the advice from Chen and colleagues[1] is outstanding, it does not take into consideration the various phases of the pandemic that may be facing the readership. In addition, one might note that many of the recommendations made by Chen and colleagues[1] are based on less than robust oncological evidence; however, this is actually very appropriate given that the recommendations are based on the best data that we have available and guidance is in high demand during this challenging time. As stated by infectious disease specialist Dr Annie Antar, "All of us want to practice evidence-based medicine, but the timeline for this might not allow us to wait for that."[7]

Chen and colleagues[1] have taken a humbling and altruistic approach, sharing information that will be of great benefit to our thoracic surgical community. In times such as this, there exists much uncertainty regarding best practices, outcomes, and consequences of the challenging decisions with which we are all faced. However, one thing is absolutely certain: Such sharing of experiences—successes, failures, and lessons learned—is imperative to enable us all to save as many lives as possible.

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